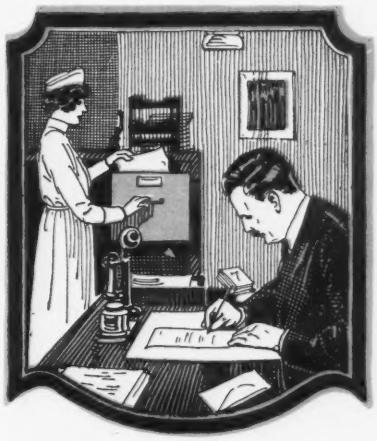
THE Canadian Hospital



A Monthly Journal for Hospital Executives

Toronto, Can. **The Edwards Publishing Company** September, 1932

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Please refer to THE CANADIAN HOSPITAL when writing

The dilemma of the modern diet

MODERN living conditions are creating a two-edged problem in menus. A recent article* states the case aptly:

"In this age of automobiles and other machines which relieve mankind of much physical labor, there is an inevitable reduction in the amount of energy which a man must ingest daily in order to maintain his body weight. With lowered intake of calories there is a danger that the other nutrients which have been customarily ingested along with the calories will also be reduced.

"It seems likely that mankind will need to give increasing attention to the ash and vitamin content of the diet until new food habits are established which guarantee new supplies of all these dietary essentials.

"One ounce of whole wheat bread will furnish 62 vitamin B units, and 100 calories; one ounce of bran suitably prepared for human use, such as has been used in this investigation, will furnish at least 45 vitamin B units with not more than about 30 calories. One ounce will also furnish vitamin B equivalent to that in one very large apple (100 calories) or 5 ounces of orange juice (60 calories). Without adding very greatly, then, to the total calories in the adult diet, bran may contribute appreciably to the vitamin B content."

But vitamin B, important as it is, is only one of the nutrients furnished by Kellogg's ALL-BRAN. This delicious ready-to-eat cereal provides "bulk" to exercise the intestines, and help promote regular elimination. Furthermore, Kellogg's ALL-BRAN supplies twice as much iron as an equal amount by weight of beef liver. In addition, ALL-BRAN contains valuable proteins and other mineral salts, which promote health generally.

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Except in cases of intestinal conditions where any form of "bulk" would be contraindicated, ALL-BRAN may be safely prescribed. Equally delicious as a cereal, or used in cooked dishes. Made by Kellogg in London, Ontario.

*Wheat Bran as a Source of Vitamin B, by Rose, Vahlteich, Funnell and MacLeod, pages 369-374, J. Am. Dietetic Assn., March, 1932.

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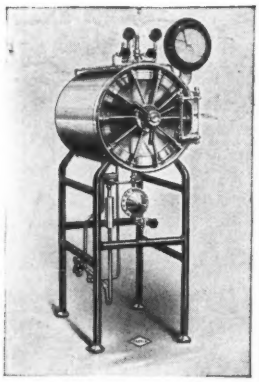
SEPTEMBER, 1932

CONCERNING VALUE

Shall it be UP to Quality?

Shall it be DOWN to Price?



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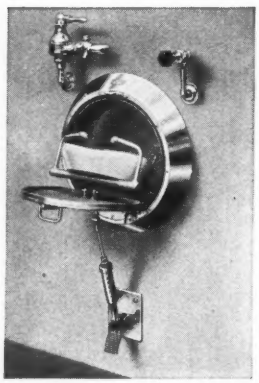

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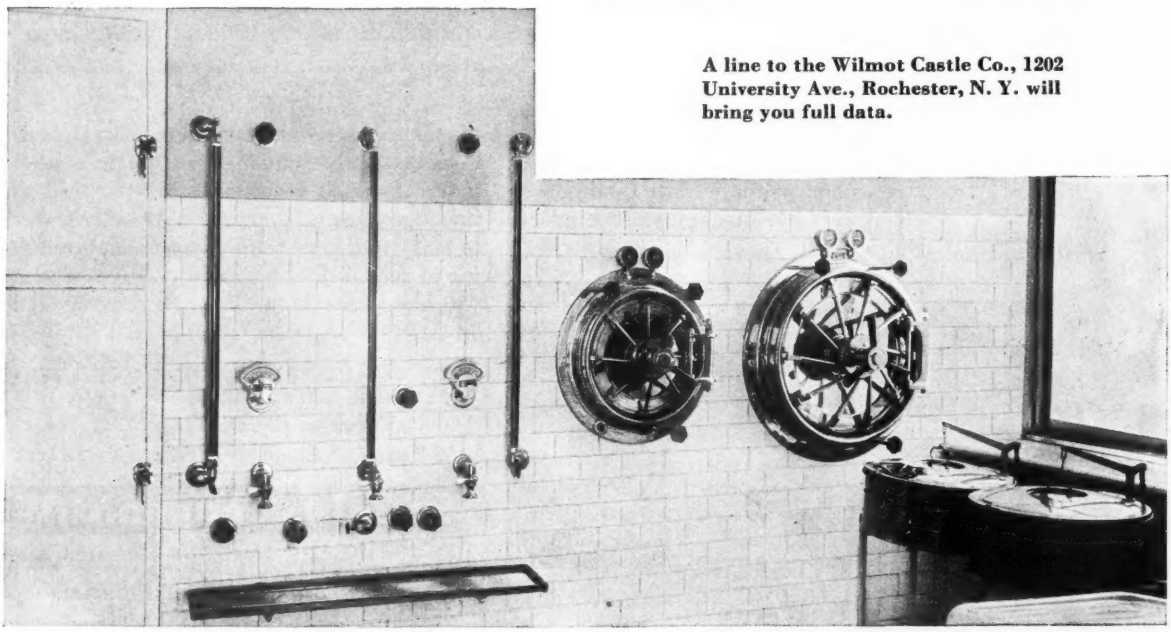
A line to the Wilmot Castle Co., 1202 University Ave., Rochester, N. Y. will bring you full data.



CASTLE STERILIZERS

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THE Canadian Hospital

Published in the interests of Hospital Executives

ISSUED ON THE FIFTH OF EVERY MONTH BY

THE EDWARDS PUBLISHING COMPANY

177 JARVIS STREET

TORONTO 2 - CANADA

C. A. EDWARDS - - - - Publisher

MARY L. BURCHER, B.A. - - Editor

TELEPHONE ADELAIDE 9634

Subscription Price $2.00

Vol. 9 SEPTEMBER, 1932 No. 9

A Suggested Hospital Medical Library

THE purpose of a medical library in a hospital should be to provide the intern and house staff with a basic working collection of the latest authoritative textbooks and well recognized reference works in the various branches of medicine.

It should be limited in scope to a working reference collection kept up-to-date by the addition of new editions and new essential special works and monographs deemed worth while for such a library.

There should be no thought or intention of building up a complete medical library in competition with other large all-inclusive medical libraries in communities where there are such facilities. There should be close co-operation with these larger collections. The hospital medical library should be created and maintained solely as a modern working collection for reference use in the institution. It should be combed from time to time to provide for the elimination of old editions and works no longer considered necessary.

Charles Frankenberger, Brooklyn, N.Y., Librarian of the Medical Society of the County of Kings, has prepared an article on this timely subject, which is of decided interest to hospital executives everywhere. Mr. Frankenberger, out of his wide experience as a librarian who has made a special study of medical literature, is well equipped to help the would-be hospital librarian to plan, equip and maintain a library that will meet the most varied demands.

A copy of "A Suggested Hospital Medical Library" will be mailed to persons who wish to become familiar with the method of procedure in bibliographic reference work, by writing to Mr. Frankenberger at 1313 Bedford Avenue, Brooklyn, N.Y.

Prepaid Hospital Care Certificates Are Adopted

IN these days of changing conditions many new ideas have been adopted by hospitals to increase revenue and at the same time to lighten the burden on the patient.

The St. Catharines General Hospital recently introduced a plan whereby anyone expecting to require hospital attention can, by payments as low as $1.00 at a time, purchase prepaid hospital care certificates of $20.00 each. These certificates will be accepted from the purchaser at their face value and the amount credited on any hospital account rendered by the hospital to the purchaser. They are not transferable, but in case the anticipated hospital service is not required the amount paid will be refunded.

This new plan will make it easier to finance anticipated hospital care, especially maternity cases, as many find it easier to save a little at a time.

Reductions have been made in the maternity ward rates and a flat rate established for tonsil, nasal and dental cases. In the maternity ward a reduction from $25 to $20 has been made for the care of mother and baby for a ten-day period. The flat rate for tonsil, nasal and dental cases varies according to private room, semi-private or ward beds, and range from $10.00 to $13.00 for the first 24 hours in a private room to $8.00 for the first 24 hours in a ward bed.

Introducing a Newcomer to Hospital Personnel

IT is with pleasure that we introduce to our readers a newcomer to hospital personnel—the Publicity Director. In particular we introduce Mrs. Beatrice E. Green, Publicity Director of the Vancouver General Hospital, who is, so far as we know, a pioneer in this field in Canada. As a background for her work Mrs. Green has to her credit seventeen years of practical experience in newspaper work. Under her own name her writings and "Reflections" are known throughout Canada, while her interviews of many world celebrities have appeared not only in the Canadian press, but in English and American newspapers as well.

At our suggestion Mrs. Green has written an article which indicates how the publicity bureau can keep the hospital before the public eye, how it can "sell" the hospital to the public, how it can make the public "hospital-minded." The article appears in this issue and we commend it to your attention.

Radio Considered a Valuable Therapeautic Agent

RADIO installations in hospitals continue to grow in number, the Nova Scotia Sanatorium at Kentville, N.S., being one of the latest to attest its faith in radio as a valuable therapeutic and educational factor. Dr. A. F. Miller, the Sanatorium's Medical Superintendent, is loud in his praise of the installation, and expects it to assist considerably in health education,

Officials of Canadian Hospital Associations

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Saskatchewan Hospital Association.

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entertainment and the maintenance of a normal state of mind, as is evidenced by his comments in the Annual Report of the Sanatorium, as follows:

"The benefit to the health and spirits of patients, especially to those undergoing a long tedious period of treatment, will readily be understood. To have the best of speeches, sermons and music, as well as the amusing and diverting numbers, and the world's news, coming to them without expenditure on their part of the precious energy which must be saved for 'the cure,' is, indeed, a pleasure that makes for contentment and a normal state of mind. Besides this, our radio will enable the physicians to give instructive talks to all patients on the subjects in which all patients need special education—personal and community health. Every discharged Sanatorium patient becomes an educator of his community, and incalculable good has been done and will be done in this way toward the control of the common enemy, tuberculosis!"

The Salesman as an Educator

IN case an occasional hospital purchasing agent has been wont to look upon salesmen somewhat as housewives look upon book agents, perhaps these words from the pen of Sidney M. Bergman, Assistant Director in charge of purchasing at Beth Israel Hospital, Boston, and published in "Hospital Management," may have some ameliorating effect. Quoting:

"Too often the person responsible for purchasing adopts an attitude of suspicion toward all salesmen, forgetting that the salesman is a fellow human being, often exceedingly well trained, and of a calibre as estimable as the purchaser. If there is one money-saving asset which accrues to the purchasing office of an institution, it is, outstandingly, the goodwill of the firms who supply merchandise. Every effort should be made to receive salesmen with courtesy. They should be made to feel that they are welcome and that at all times they will get a square deal. The salesman is not only a convenient means for obtaining merchandise, but he is also an educator. Very frequently he can save the institution a great deal of money because of his superior knowledge of his own field."

Co-operation is the basis of satisfactory results in many departments of the hospital, and happy relations between buyer and seller are well worth cultivating.

According to a recent statistical bulletin of the Metropolitan Life Insurance Company, the health record of 1931 among Canadian wage earners and their dependents was even more remarkable than that registered among the industrial population of the United States. The death-rate among Canadian wage earners and their dependents insured in the Industrial Department of the Metropolitan Life Insurance Company was actually seven per cent *below* the previous minimum.

"Reforms are the fruits of painstaking labour and mutual compromise and of advancing step by step; they do not spring like Minerva, full grown, from the head of Jupiter."—*Bismarck.*

The Economics of Hospital Planning

By B. EVAN PARRY,
Parry and Smith, Architects, Toronto.

OLD Man Depression's finger prints can be found to-day on most of our hospitals in the Dominion, and is having the same effect on hospital authorities as with Governments, Industrialists, and so on down the line to the Housewife. Where can we economize?

For some years we have been trying to "keep up with the Jones'" in our hospital construction and in consequence have expended large sums of money. Nevertheless we must not lose sight of the fact that hospitalization to-day is a very different thing to that which obtained sixty years ago. It had no well equipped accident room, no elevators, no electric light—only dim gas light or oil lamps. It had no X-ray department and no trained nurses in trim white uniforms. A patient had none of the advantages of a private room, because there were no private rooms. Whether he wished it or not, he would most likely find himself in an open ward with persons who were suffering with all kinds of diseases.

Compare this with the conditions of two years ago when it was estimated that approximately one million dollars per day were being poured into hospital construction, to provide private, semi-private and ward beds; individual toilets, baths, utility and storage rooms; examining, treatment and consulting rooms; ward laboratories; solaria; rooms for visitors; operating and maternity departments; out-patients' department with clinics; elevators; laundries, public waiting and reception rooms; emergency contagious units; power and heating plants; refrigeration and ventilation; sound deadening construction, and accommodation for nurses.

It is true that the cost of hospitals is an important item in the social budget, but, on the other hand, the public demands so-called necessities to-day which in the past would have been looked upon as luxuries.

It should be realized that hospital planning is a complicated art, that it involves grave social responsibilities and that the proper evaluation of the usefulness of a hospital building can not be made without much study. There is a growing feeling among the members of the medical profession that this phase of hospitalization should be the subject of study—one might say intensive study—by those concerned with human welfare, including members of the medical and nursing professions, sociologists, engineers and architects. Only by such means can the grievous blunders being made every day be averted.

The hospital as at present organized must represent the brain centre of all those activities which benefit the individual sick and the health of the community within its sphere of influence; although all hospitals should not be expected to carry on the extensive functions centering around the patient, but rather to appreciate that the care of the patient is the primary function and that each hospital must work out for itself the extent of the field which it is able to properly cover.

It should never be said that the cost of hospital construction is so much per bed in the arbitrary way in which many so-called authorities on hospital planning have the habit of doing . . . . The first requisite of a theory of the economics of hospital planning is a unit of value . . . The totality of the service which hospitals render to the sick is the real measure of their value, but such services are of too many kinds to be expressed in a single mathematical term.

The architect must be imbued with this conception of the essential functions of a hospital if he is to produce a "well-rounded out" result.

Hospital costs vary, as also hospital values. It should never be said that the cost of hospital construction is so much per bed in the arbitrary way in which many so-called authorities on hospital planning have the habit of doing. Generally it is to be found that such advice emanates from the man of a somewhat limited experience, since there are different grades of various types of hospitals.

The first requisite of a theory of the economics of hospital planning is a unit of value. Such a measure is not easily defined. The totality of the service which hospitals render to the sick is the real measure of their value, but such services are of too many kinds to be expressed in a single mathematical term.

If hospital costs vary, so also do hospital values. Whereas a hospital planned and equipped merely for the shelter of the sick, for the administration of simple remedies, for the performance of slight laboratory tests and of routine surgical procedures, may be built at a relatively small cost, one which is generously equipped in research and for teaching requires a much greater outlay.

The actual cost of a hospital building is of great practical importance to the building committee. But in a theoretical approach to hospital planning, the mere cost of construction can not be accepted as a ruling factor.

The size and composition of a correctly planned hospital building and the character of its equipment, which basically determine cost, must be deduced from functional needs.

Arrangement and equipment are determined by administrative principles. It may be well for me to give you the composition of a one hundred bed hospital, for which I acted as consultant, i.e.:

The project would consist of three buildings, namely:

1. Main hospital building.
2. Heating plant, laundry, male and female helps' accommodation.
3. Nurses' home.

Main Hospital — Lower Ground Floor

Food service department.
Dining rooms.
Lecture room for nurses' post graduate course.
Therapeutic department, including hydro and physiotherapy.
Two special case wards with toilet accommodation.
Store rooms.
Central linen and blanket store.
Casualty and emergency department.
Morgue and autopsy.
Ambulance entrance.
Out-patients' department consisting of waiting hall, 4 examination rooms and clinics, toilets, public telephone booth.
Central pharmacy.

First Floor (Administration and Public Wards)

Administration department.
Board room for staff and trustees.
Superintendent's suite.
Library and lounge room.
Doctors' cloak room and toilet.
Internes' accommodation.
Patients' wards.
Public rest room.
Necessary utilities.
Linen room.
Flower room.
Isolation unit of 10 bed capacity, with outside entrance, as also access from main hospital.

Second Floor (Operating Department)

Major and minor operating rooms with sterilizers and scrub-ups, the walls of the operating rooms to be provided with apertures for view boxes.
Nurses' work room with robing room and toilets leading therefrom.
Eye, ear, nose and throat department with dark room.
Anaesthetic room.
Laboratory and work room.
Doctors' showers, lockers and toilets.
X-ray department, provided with waiting room with dressing cabinet.
Cardiograph room.
Fracture room.
Fluoroscope room with toilet and dressing cabinet.
Cystoscopic room.
Office for charts, records, etc.
Necessary utilities.

Third Floor (Obstetric Department)

Two delivery rooms.
Two labour rooms.
Scrub-up room.
Sterilizing room.
Doctors' rest room.
Patients' wards with toilets.
Private nurses' rest room.
Office for charts, records, etc.
Nursery, capacity 30 cots, with babies' wash room and isolation unit in connection therewith.
Room for premature babies, known as incubator room.
Necessary utilities.

Fourth Floor (Medical and Surgical)

Wards for patients, with all necessary utilities, toilets, etc.

Fifth Floor (Pediatric and Solaria Departments)

One six bed boys' ward.
One six bed girls' ward.
Observation ward with separate toilet thereto.
Diet kitchen.
Play room.
Solaria.
Two solaria, one for male and one for female patients of hospital generally.
Roof gardens.
Nurses' room with toilet.
Diet kitchen.

All the floors being served by elevators and staircases.

Composition of Wards

Private rooms - - -	47
Semi-private rooms - -	13
Six bed wards - - -	5

(Exclusive of children's wards.)

Heating Plant — Lower Ground Floor

Devoted to heating and power plant, engineer's room with toilet, work shop both for engineering repairs as also furniture and painting, etc.

First Floor

Laundry.

Second Floor

Accommodation for male and female help, segregation of sexes to be closely observed. A common room to be provided.

Well planned general hospitals range from 8,000 to 16,000 cubic feet of construction for each patient's bed, and the higher as well as the lower of these limits has been explained and defended on grounds of administrative policy. One factor is that hospitals which care for both private and ward patients demand the greatest space.

Costly service features can be well studied to effect economics, and the eagerness to excel in the richness of mechanical equipment has been responsible for reckless expenditures.

The cost of hospital construction during the past decade has been considerably augmented by the growth of out-patient, X-ray, biologic, chemical, pathological, operating, physiotherapy and nursing departments. Further, the substitution of fireproof buildings with interior sanitary finish and a multiplicity of plumbing fixtures has at least doubled the cost of each cubic foot of construction.

Taking a general hospital of five hundred bed capacity recently constructed, it worked out at a figure of 12,000 cubic feet of total hospital construction for each patient's bed. This hospital included contagious, psychiatry and tuberculosis departments.

The administrative, food service, laundry, storage, heating and ventilation services have also developed considerably and take up considerable space.

The following statistics of a two hundred and fifty bed hospital will give an idea as to what is meant by space taken for various units, i.e.:

Public wards—800 to 1,000 cu. ft. per bed.
Private wards—1,000 to 1,750 cu. ft. per bed.
Out-patient department—70,000 cu. ft.
X-ray—10,000 cu. ft.
Laboratories—3,000 cu. ft.
Operating department—50,000 cu. ft.

(Continued on page 25)

The Admission and Discharge of Patients

By SR. HARQUIL, R.H., R.N.,
Hotel Dieu Hospital, Campbellton, N.B.

THE Admitting Office is one of the key positions of the hospital. It should be as near to the entrance as possible and should not be too business-like in appearance—a little home touch to it, as the patient comes there with fear and trembling anticipating unpleasant experiences—is very desirable. It should be provided with all the necessary equipment to enable the personnel to despatch the business transacted there with due speed so as not to detain the patient too long. In small hospitals, the admitting office and business may be in one, but should circumstances require that they be in separate rooms, they should be as near as possible to each other so that information on the financial standing of a patient, who may have been in the hospital before, can be obtained in a short time.

Personnel. Should be picked — preferably women, neatly dressed. Personality counts far more in an admitting clerk than professional standing. She, whether a Sister or a secular, should be courteous and well trained. Mr. Joly says she should wear a million dollar smile. She should be tactful, kind, understanding; above all else, she should be a judge of human nature. She should in addition to all this have executive ability, some medical or nurses' training, a knowledge of the economic conditions of the community and its social agencies, and of the courage of her convictions with the gift of yielding graciously when the occasion warrants. A knowledge of social service is valuable. She should be a member of the Administrative Department and should have supervision of all admissions. She is the hospital's financial representative in the establishment of rates to the patient and in the collecting of accounts to the extent of obtaining the initial deposit and at times providing credit for reliable patients. Her duties require an accurate knowledge of the hospital's census at all times and she may have to look after a part of the hospital's correspondence, particularly about admission of patients.

Reception of the Patient. No phase of hospital work can be more productive of friendliness and good will than the proper reception of the patient. Initial contact must be cordial, almost friendly — show the patient and his relatives you are glad to see them, that you are interested in them, that you are ready to serve them, and they will be impressed immediately and filled with confidence in you and in the hospital. Give them the idea that you expect the patient to get better. With confidence in the attending physician and friendliness and gratitude towards the institution, the patient's recovery is more definitely assured and expediated since psychological factors play an important part in the speed with which health is restored.

Often the admitting officer under the stress of duties and haste inclines to brusqueness—this gives the patient the idea that the institution is heartless—too big to admit of understanding sympathy. But if efficiency is silver, sympathy is golden, and it must characterize not only the admitting clerk, but also the floor supervisor who receives the patient and all along the line until he is discharged.

Financial Arrangements. Ninety-five per cent. of your collection problems will be handled if you have the right kind of admitting clerk, as financial troubles begin after the patient passes the front door. There cannot be any set rule to follow in the financial question and each patient must be handled individually. If in the judgment of the admitting officer the patient is too ill to speak about business matters, after seeing that he is comfortably seated, arrangements should be made with the person accompanying him. A great deal of tact and diplomacy must be used in discussing money matters; there must be kindness and leniency tempered with firmness, persistence and sound business methods, and when arrangements are finished both parties should know exactly where they stand and the hospital should have the patient classified as pay-cash, pay with credit, free. When a free patient leaves the admitting office no one else in the institution should know him as such, and there is then less danger of some thoughtless employee slighting him by reason of his poverty.

In looking over some literature on the part of the question now under consideration, I came across the following statement which may be useful. An adult of sound mind and 21 years of age is responsible for his expenses, for minors both parents are responsible, in case of dispute the parent bringing the child to the hospital; for a married woman, husband is responsible; an adult married woman, divorced, must pay her own bills. It is not wise to write the name of an insurance company as responsible for payment, as this would indicate that you are extending credit to the company and not looking to the individual for payment, and would be damaging evidence in court against the collection of the account from the patient, but a note that the patient is insured should be entered in the patient's ledger.

Discharge. No patient should leave the hospital except by a written order of the attending physician; a phone order to a responsible person may be carried out provided that it is written and signed by the doctor as soon as possible after. Under no consideration should a patient be allowed to leave the hospital against the doctor's advice unless he sign a release exonerating the doctor and the hospital authorities. As soon as the time of departure is determined upon, the account should be made out and final arrangements made with the patient or the responsible relative; on this occasion the same tact and persistence should be used as on admission, but if the preliminary arrangements have been well made the departure will be pleasant. The patient should be conducted to the door by the floor supervisor or a responsible nurse, preferably one who had care of him, and she should remain with him until he leaves.

The departure should be such as if he were ending a

(Continued on page 21)

Suggestions recommended in a demonstration given by Sr. Harquil, R.H., R.N., Hotel Dieu Hospital, Campbellton, N.B., at the Annual Convention of the Maritime Conference of the C. H. A., St. John, N.B., June 28-29, 1932.

Nurses Home and Isolation Section of Queen Charlotte's Maternity Hospital at Hammersmith, England

Sunlight and Colour Are Factors in This Well Equipped English Hospital

ILLUSTRATED on these pages are rooms from the Nurses' Home and Isolation Section of Queen Charlotte's Maternity Hospital at Hammersmith, England. It will be seen that those responsible have realised to the full the great part played by colour and light, both in sickness and health. Lower left is a nurse's bedroom in cream and pale blue with oak furniture, the bedside chair being upholstered in multi-coloured tapestry. Lower right is the Common Room, with light beige walls. This has Persian rugs with which the Jacobean design loose-covers of the easy chairs and settees blend well. These two rooms are part of what was a large, private house, particularly well-lit and airy, adjoining which has been built the new Isolation Hospital of which we show, upper left, part of one of the wards.—*Courtesy of the Furnishing Trades Organizer, London, Eng.*

Desirability and Advantages of Hospital Aids Section Within Hospital Associations

By MARGARET RHYNAS,
President, Women's Hospital Aids Association.

HOSPITAL aids and their relation to hospitals would seem a timely subject upon which to write a brief article—relative to the frequent question — what are the advantages of a Hospital Aid Section within the Hospital Associations.

As President of the Provincial Association of Ontario, and also as advisory convener, I have acquired an intimate knowledge of the achievements, possibilities and ideals of Hospital Aids within the Affiliation.

Hence I take the liberty of expressing a few concrete facts upon the foregoing subject.

First, may I say that since hospitals opened their doors to serve the sick and suffering, voluntary women have played no small part in assisting the Hospital Board and Superintendent to build up and maintain a service in the community to carry on this noble work.

This large army of volunteer women have developed within their ranks hospital consciousness and have spread the gospel of hospital mindedness in the community. I do not hesitate to say that in some instances small hospitals could not exist if it were not for the strong arm extended to them by the Hospital Aid.

Through this sympathetic contact between hospital and community a better understanding of all that pertains to hospital administration is interpreted to the citizenship.

This plant of benevolence has grown until its branches are found interwoven into almost every hospital whether large or small, and it is felt by those who have an intimate knowledge of the extent and possible scope of the work that linking up with the Ontario Hospital Association has kept the Hospital Aids Association abreast with the ever-turning wheels of development in the hospital field.

It is realized that larger vision can only be gained through a wider field of experience, hence the linking up with the Hospital Association affords interchange of ideas and an opportunity to embrace through experts of every branch of hospital activity (which is found within this body of hospital specialists) limitless knowledge and prestige.

As the aids also represent a large co-purchasing power, it would seem feasible to open every avenue of information. The products exhibited and demonstrations given during the annual convention and various group conferences serve to familiarize the membership with first hand knowledge of hospital supplies and administration. It may surprise some to know that over one million dollars has been expended by the affiliated aids in hospital up-keep and equipment and that from up-to-date ambulances to small culinary articles are purchased by this body who represent the volunteer hospital aid membership.

The Hospital Aids Association stands not only for co-operation with Board and Superintendent but every department within the hospital sphere.

The motto of the Association is as follows:

We do not want to run hospitals—we want to make it easier for Hospital Boards and Superintendents to do so.

Then too, we have many aids sponsoring clinics. One aid within the affiliation is responsible for a convalescent fresh air camp for crippled and cardiac children (underprivileged). Seventy are given expert care and treatment during their two months' sojourn as guests of the Aid. Occupational therapy under an experienced therapist is provided this camp.

Social service in connection with the hospital is also one of the many activities within the Hospital Aid scope. One Hospital Aid within the affiliation has twelve thousand dollars in readiness to assist in furnishing when a contemplated extension programme of the hospital is realized.

Is there any other body connected with hospital activities contributing such assistance? It surely means something in times like these — "a rut differs from a groove only in its depth.

We are all apt to get into a rut—forgetful of advancing advantages. We feel in extending our interest in joining up with the Hospital Associations that we are hitching our wagon to a star and getting away from time-worn ideas of following old ways and customs. In any venture one must have courage and vision. Let us all keep our hearts and minds open to advancing needs—and equip ourselves to meet them.

A chain is as strong as its weakest link, hence we should strive to weld together every link in the silver chain encircling Hospital Aid service to the hospital.

The Hospital Aid Section within the Ontario Hospital Association affords the rank and file of Hospital Aid membership opportunity to observe every phase of hospital activities and intercourse with hospital experts. May we all become sensible to these advantages and take advantage of this great opportunity by attending these meetings—then and only then may we expect to render the most efficient and telling service to the hospitals.

Hospital Aids have played a large part in advancing the celebration of Open Hospital Day, May 12th, Florence Nightingale's birthday, and have been always keenly interested in the student nurse, taking part in the graduation exercises and presentations, the entire life of the hospital and all that pertains thereto. Sewing groups make and mend linen supplies and lend their services in any capacity the Superintendent may deem feasible. Jam and fruit and also pickle showers provide many hospitals with supplies of home done relishes and jams.

In closing may I ask you, have you ever considered the power behind this large group of volunteer hospital workers, and what valuable assistance could be given and influence felt in advancing legislation measures to benefit hospitals?

We have been given large opportunities, let us equip ourselves adequately to cope with our responsibilities.

Programme of Ontario Hospital Association

October 26-28, Royal York Hotel, Toronto

Some of the features of the programme are as follows:

FIRST DAY, OCTOBER 26th

Address of Welcome by Mayor W. J. Stewart.

Presidential Address: Mr. F. D. Reville.

Morning Session—Report of Hon. Secretary-Treasurer, Dr. Fred. W. Routley.

Address by the Hon. Dr. J. M. Robb, Minister of Health.

12.30 noon—General Luncheon. Speaker, Dr. Grant Fleming, Director Dept. of Public Health and Preventive Medicine, McGill University, Montreal: "The Place of the Voluntary Health Organization."

Afternoon Session—Discussion of the Survey of Nursing Education in Canada, by Professor G. M. Weir.

Chairman: Dr. Harvey Agnew.

Speakers: Dr. G. Stewart Cameron, Peterborough; Dr. Duncan Graham, Toronto; Dr. George Young, Toronto; Miss M. McKee, Brantford; Miss Jean Brown, Toronto.

Round Table Discussion on Nursing Problems.

Evening Session—Sectional Meetings.

SECOND DAY, OCTOBER 27th

Paper: "The Mental Hospitals." Dr. B. T. McGhie.

Paper: "The Catholic Hospitals." (Speaker not yet selected.)

Address: "The Health Work of the League of Nations." Dr. J. G. Fitzgerald, Dean of Medicine, University of Toronto.

Afternoon Session—Address: "The Hospital Trustee." Mr. Hugh Nickle, Kingston.
Mr. H. Southcott, St. Catharines.

Round Table Discussion on questions pertaining to Trustee Problems.

Chairman: Dr. W. Dobbie, Superintendent, Weston Sanatorium.

Evening Session—Annual Banquet and Dance, Ball Room Royal York Hotel.

THIRD DAY, OCTOBER 28th

Morning Session—Reports of Sections (a) Trustees; (b) Nurses; (c) Hospital Aids.

Report of the Survey of the Hospital Inter-Relations Committee of the Ontario Medical Association. Dr. F. C. Neal, Peterborough.

Discussion opened by Dr. Malcolm MacEachern, Director of Hospital Activities, American College of Surgeons, Chicago.

Afternoon Session—Symposium on Convalescent Care.

Miss Laura Gamble, R.N., Toronto.

Dr. Olive Cameron, Toronto.

Dr. D. E. Robertson, Toronto.

Miss Tansey, Superintendent, Montreal Convalescent Hospital.

Miss Stewart, Montreal.

Dr. Harvey Agnew, Secretary, Dept. of Hospital Service, Canadian Medical Ass'n, Toronto.

Hospital Aid News

MIDLAND.—Two active Hospital Aids are doing excellent work for their local hospital. The Senior Aid looks after the linen supply, making an inventory twice a year, so as to keep the linen cupboards well filled. The Junior Aid are responsible for general equipment. Recently a successful tea and bake sale was held at "busy Ways" on the Georgian Bay, the beautiful summer home of Mrs. F. W. Grant, who is an active member of the Senior Aid. This is a popular yearly event and cottagers and visitors look forward to this social and remunerative function.

* * *

HAMILTON. — The Hamilton Hospital Auxiliary is again conducting a very successful Children's Convalescent Camp at Brant House, Burlington. Mrs. P. B. MacFarlane is the President of the Auxiliary and Miss Agnes Climie, the efficient convener of the committee in charge.

During July thirty-five boys, and in August thirty-five girls enjoyed a month's holiday under the splendid supervision of Miss Walker, Reg. N., with Miss Jackson, Reg. N., and Miss Milne, Occupational Therapist, assisting.

Mrs. O. W. Rhynas, President of the Provincial Association, recently entertained at luncheon for the members of the Advisory Committee at the Royal Connaught Hotel, Hamilton. A business meeting followed, when further arrangements were made for the Women's Hospital Aids Association to be held at Sarnia, Oct. 5th and 6th.

* * *

Convention News

Hon. W. S. Martin will be the guest speaker at the banquet to be tendered the delegates by the Sarnia Aid. The Advisory Committee feel that a rare treat is in store for the members, who will have the privilege of hearing this eloquent speaker.

* * *

A number of films will be shown and demonstration given on Occupational Therapy. This should prove an interesting feature of the Convention programme for the first day.

* * *

Mr. F. Douglas Reville, President of the Ontario Hospital Association, and Chairman of the Hospital Board, Brantford, will attend and bring greetings from the Hospital Association.

* * *

One of the outstanding addresses of the Convention will be that of Dr. Helen McMurchy, chief of Div. Child Welfare Dept. of Pensions and National Health, Ottawa. Dr. McMurchy will also attend the banquet.

* * *

The following committee conveners have been appointed by the Sarnia Aid: Transportation, Mrs. A. Gort, 112 Charlotte St.; Reception, Mrs. D. MacMurphy, 349 George St.; Registration, Mrs. H. C. Bayne, 123 James Street.

* * *

Affiliated Aids please note:—Forward names of delegates as soon as possible.

THE development of the atraumatic suture with needle integrally affixed eliminated two of surgery's oldest problems—the trauma produced by the double thickness of suture material and the tendency of needles to become un-threaded. D&G Atraumatic Sutures, originally designed for gastro-intestinal work, are now available in a variety of materials with needles of suitable shape and size for most situations where minimized suture trauma is desired.

INTESTINAL—Straight, three-eighths circle and half-circle needles on plain or chromic catgut. Sizes 00-0-1.

ARTERY—Straight needle (¾ inch) on 000000 black silk.

EYE—Small, three-eighths circle needle on 0000 black silk. Half-circle needle on 000000 black silk. Three-eighths circle needle on 000 plain catgut.

NERVE—Straight needle (⅜ inch) on 000000 black silk.

PLASTIC—Small, half-curved needle on 0000 Kal-dermic Skin Suture or black silk. Three-eighths circle needle on 000000 Kal-dermic Skin Suture.

OBSTETRICAL—Large, full-curved needle on chromic catgut. Sizes 2-3.

CIRCUMCISION—Small, full-curved needle on plain catgut. Sizes 00-0

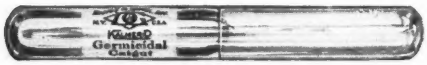
Prehistoric needle, modern eyed type needle, and the improved D&G Atraumatic Suture with needle integrally affixed.

D&G Atraumatic Sutures

D&G Sutures PRICE LIST FOR DOMINION OF CANADA

Kalmerid Catgut

GERMICIDAL. Exerts a bactericidal action in the suture tract. Supersedes the older unstable iodized sutures. Impregnated with the double iodine compound, potassium-mercuric-iodide. †Heat sterilized.



The boilable grade is unusually flexible for boilable catgut; the non-boilable grade is extremely flexible.

TWO VARIETIES

BOILABLE* NO.		NON-BOILABLE EXTREMELY FLEXIBLE
1205	PLAIN CATGUT	1405
1225	10-DAY CHROMIC	1425
1245	20-DAY CHROMIC	1445
1285	40-DAY CHROMIC	1485

Sizes: 000 . . 00 . . 0 . . 1 . . 2 . . 3 . . 4

Approximately 60 inches in each tube

Package of 12 tubes of a size $3.60

Kalmerid Kangaroo Tendons

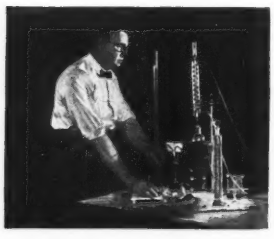
GERMICIDAL, being impregnated with potassium-mercuric-iodide.† Chromicized to resist absorption in fascia or in tendon for approximately thirty days. The non-boilable grade is extremely flexible.

NO.	
370	NON-BOILABLE GRADE
380	BOILABLE GRADE

Sizes: 0 . . 2 . . 4 . . 6 . . 8 . . 16 . . 24

Each tube contains one tendon
Lengths vary from 12 to 20 inches

Package of 12 tubes of a size $3.60

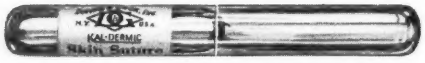


D&G Sutures are always found neutral under the most delicate titration tests. This is one of the reasons they uniformly behave well in the tissues.

Kal-dermic Skin Sutures

"IDEAL FOR DERMA-CLOSURE"

A NON-CAPILLARY, heat sterilized suture of unusual flexibility and strength. It is uniform in size, non-irritating, and of distinctive blue color. Boilable.



NO		INCHES IN TUBE	DOZEN
550	WITHOUT NEEDLE	60	$3.60
852	WITHOUT NEEDLE	20	1.80
954	WITH ½-CURVED NEEDLE	20	3.00

Sizes: 000 (FINE) 00 (MEDIUM) 0 (COARSE)

In packages of 12 tubes of a kind and size

Kal-dermic Tension Sutures

IDENTICAL in all respects to Kal-dermic skin sutures but larger in size.

NO.		INCHES IN TUBE	DOZEN
555	WITHOUT NEEDLE	60	$3.60

Sizes: 1 (FINE) 2 (MEDIUM) 3 (COARSE)

In packages of 12 tubes of a kind and size

Intestinal Sutures

WITH Atraumatic Needles integrally affixed to 20-day Kalmerid catgut. For gastro-intestinal work and membranes where minimized trauma is desirable.

THEY DO NOT BEND HERE

NON-BOILABLE *(Extremely Flexible)*

NO.		SUTURE LENGTH	DOZEN
1541	STRAIGHT NEEDLE	28	$3.60
1542	TWO STRAIGHT NEEDLES	36	4.20
1543	⅜-CIRCLE NEEDLE	28	4.20
1545	½-CIRCLE NEEDLE	28	4.20

BOILABLE

1341	STRAIGHT NEEDLE	28	$3.60
1342	TWO STRAIGHT NEEDLES	36	4.20
1343	⅜-CIRCLE NEEDLE	28	4.20
1345	½-CIRCLE NEEDLE	28	4.20

Sizes. 00 . . 0 . . 1

In packages of 12 tubes of a kind and size

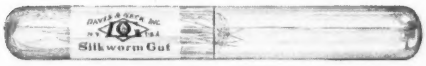
DISCOUNT ON QUANTITIES

DAVIS & GECK, INC. ▾ 217 DUFFIELD ST. ▾ BROOKLYN, N.Y.

D&G Sutures are obtainable from responsible dealers everywhere; or direct, postpaid

PRICE LIST FOR DOMINION OF CANADA **D&G Sutures**

Unabsorbable Sutures



NO.		INCHES IN TUBE	SIZES
350	CELLULOID-LINEN	60	000, 00, 0
360	HORSEHAIR	168	00
390	WHITE SILKWORM GUT	84	00, 0, 1
400	BLACK SILKWORM GUT	84	00, 0, 1
450	WHITE TWISTED SILK	60	000 TO 3
460	BLACK TWISTED SILK	60	000, 0, 2
480	WHITE BRAIDED SILK	60	00, 0, 2, 4
490	BLACK BRAIDED SILK	60	00, 1, 4

BOILABLE

Package of 12 tubes of a size.....$3.60

Short Sutures for Minor Surgery

NO.		INCHES IN TUBE	SIZES
802	PLAIN KALMERID CATGUT	20	00, 0, 1, 2, 3
812	10-DAY KALMERID "	20	00, 0, 1, 2, 3
822	20-DAY KALMERID "	20	00, 0, 1, 2, 3
862	HORSEHAIR	56	00
872	WHITE SILKWORM GUT	28	0
882	WHITE TWISTED SILK	20	000, 0, 2
892	UMBILICAL TAPE	24	⅛-IN. WIDE

BOILABLE

Package of 12 tubes of a size.....$1.80

Emergency Sutures with Needles

UNIVERSAL NEEDLE FOR SKIN, MUSCLE, OR TENDON

NO.		INCHES IN TUBE	SIZES
904	PLAIN KALMERID CATGUT	20	00, 0, 1, 2, 3
914	10-DAY KALMERID "	20	00, 0, 1, 2, 3
924	20-DAY KALMERID "	20	00, 0, 1, 2, 3
964	HORSEHAIR	56	00
974	WHITE SILKWORM GUT	28	0
984	WHITE TWISTED SILK	20	000, 0, 2

BOILABLE

Package of 12 tubes of a size.....$3.00

The ash of D&G Sutures is assayed to make sure that no traces remain of uncombined chromium nor of other residues of the chromicizing process.

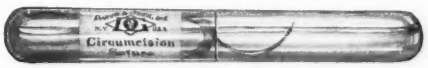
Obstetrical Sutures

FOR immediate repair of perineal lacerations. A 28-inch suture of 40-day Kalmerid germicidal catgut, size 3, threaded on a large full-curved needle. Boilable.*

No. 650. Package of 12 tubes....$4.20

Circumcision Sutures

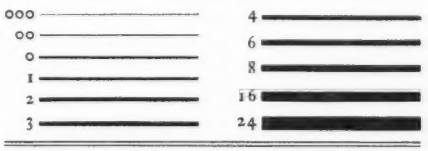
A 28-INCH suture of Kalmerid germicidal catgut, plain, size 00, threaded on a small full-curved needle. Boilable.*



No. 600. Package of 12 tubes....$3.60

Universal Suture Sizes

All sutures are gauged by the standard catgut sizes as here shown



*These tubes not only may be boiled but even may be autoclaved up to 30 pounds pressure, any number of times, without impairment of the sutures.

†Potassium-mercuric-iodide is the ideal bactericide for the preparation of germicidal sutures. It has a phenol coefficient of at least 1100; it is not precipitated by serum or other proteins; it is chemically stable—unlike iodine it does not break down under light and heat; it interferes in no way with the absorption of the sutures, and in the proportions used is free from irritating action on tissues.

DISCOUNT ON QUANTITIES

DAVIS & GECK, INC. ▾ 217 DUFFIELD ST. ▾ BROOKLYN, N.Y.

Printed in U.S.A. ▾ The Private Press of Davis & Geck, Inc. ▾

SUTURES IN ANCIENT SURGERY

GIOVANNI ANDREA DALLA CROCE, a Venetian surgeon of the middle XVIth century, made two valuable contributions to surgical literature—a correlation of synonyms for surgical diseases from the Arabic, Greek and Roman, and illustrations of practically every surgical instrument then known. Among other interesting observations in his *Seven Books of Surgery* is mention of a successful hysterectomy, and detailed descriptions of the principal classic and contemporary methods of wound closure.

The Admission and Discharge of Patients

(Continued from page 11)

visit to a home where he had been royally entertained and he will feel a certain regret in leaving. A patient who leaves a hospital in this attitude of mind need not be asked if he is satisfied, if he was well treated, if the nurses were kind to him or the food was well cooked and promptly served, and he is the one who will recommend the hospital to his friends.

Is it too much to ask of our hospitals to aim at a very high ideal of service to the patient? It will never be reached in its perfection because we are all "human" beings, but going forward with a high ideal in view will help much in the betterment of service in this particular department, and the number of dissatisfied patients will be greatly diminished.

The Teller Test Gives Proof of Sterilization

To be free from every suspicion of inaccuracy, and to have a constant audit of thoroughly effective sterilization, are the claims made by the inventor of the Teller Test.

This little device comprises a laboratory reagent test and color process to indicate just what happens inside an autoclave during sterilization. It shows by the word "Septic" legibly and clearly when the dressings are not sterile. It changes at 250°F and shows the words "Sterile, 20 minutes" on a red ground when that temperature has been maintained continuously for twenty minutes. Lapse of steam pressure, or insufficient penetration of the steam through the dressings, or any other mischance occurring inside the autoclave is detected and indicated in definite phrase and colour.

The "Teller" has been standardized to act at 250°F and the colour process evolves at 20 minutes of that temperature. The reagent is contained within a small sealed glass tube that cannot contaminate the dressings within which it is placed. No deleterious or injurious chemical can possibly be absorbed into the gauze or cotton.

Based on the bacteriological determination of thorough destruction of every known pathogenic spore when exposed to steam at 250°F for twenty minutes, the Teller tells when that has been accomplished inside the dressings. If the steam temperature be insufficient the Teller tells. If penetration is not complete and thoroughly through the drums or bundle of dressings the Teller tells. If condensation interferes with either the temperature or the penetration the Teller tells. It checks against any inaccuracy deviating from the required standard of 250°F for twenty minutes, and it also endorses the efficiency of the sterilizing process when that standard is maintained.

Mr. W. Hargreaves, who is well known to hospital executives in Ontario, as well as the West, is the inventor of the Teller Test, and it is being sold through the Stevens Companies.

"Much more profitable is doctrine by example than by rule."—*Spencer.*

How the Publicity Bureau Can Keep the Hospital Before the Public Eye

By BEATRICE E. GREEN,
Publicity Director, Vancouver General Hospital.

MUCH has been said and written of the need and the right of hospitals to use publicity, or in other words to make some concerted effort to sell themselves to the public in the proper way. In most communities such institutions often find themselves and their work hampered by unjust and unfair criticism, and the best method of fighting such unfriendliness has been found to be the dissemination of correct information.

I have been asked to tell in my own way what we are doing in the publicity line at the Vancouver General Hospital. Slightly over a year ago, the Board of Directors, at the request of Dr. A. K. Haywood, the General Superintendent, decided that some form of publicity was an absolute necessity if long standing criticism was to be overcome and more friendly public sentiment created. It was felt that the success of future hospital programmes depended considerably upon the accomplishment of these desirable ends. As a result, I was asked to take over this work, and the hospital's own bureau of publicity became an accomplished fact.

MRS. BEATRICE E. GREEN,
Publicity Director, Vancouver General Hospital, Vancouver, B.C.

There were, of course, a few obstacles to overcome at first, but in a very short time the press and the public realized that the hospital had branched out for its own publicity. Now, everybody on the newspapers is friendly and we get the maximum of co-operation. Consequently the public is being educated to our needs and accomplishments and is fast becoming "hospital-minded."

The first essential in moulding public opinion is the newspaper, daily, weekly, or both, as the case may be. Newspapers are always willing to accept news. It is their business to seek it, and there is always good news to be found in a hospital. But—and here is where the "but" comes in—it must be news. You can't disguise propaganda and get by with it as news. But you *can* feed the papers plently of news and get them to accept a fair amount of propaganda in return for "services rendered." In other words you can give them many sprats before you catch a mackerel.

This is the way we find that it works out. Your admitting department, for instance, should co-operate to the fullest extent with regard to news of accidents, etc. The newspapers usually telephone four or five times a day and they are always given information concerning those injured in any way. This is the news! But it is very necessary that the various editors be handled carefully, and while some news may be telephoned in, I find that you have a far better chance of getting your news stories across if you write them in good newspaper language and deliver them personally while they are still news. This enables you to let them know that they are getting a very special service from you, and creates the friendly feeling you desire, so that in the event of something happening at your hospital which you do not want published, you will have no difficulty in getting it withheld.

There are many forms of real news materializing in hospitals. The papers are always glad to get stories of any special emergency, of new equipment or departments, and particularly feature stories. The number of births at New Years or on St. Patrick's Day create interest. Leap Year babies are always good copy. Conventions of doctors or nurses can be properly covered along news lines, while human interest stories of the Out-Patients' Department and of the baby clinics go over well with most editors. I also find that speeches of the Superintendent and the Chairman of the Board are almost always accepted if given to the papers immediately. All these things keep the hospital well before the public eye, and very soon people begin to realize that there really is something to this business of running a hospital.

While the newspapers are perhaps the best medium for publicity, there are others, equally effective if carried on persistently. Last June we started a card system of indexing babies born in the hospital, and commenced sending them birthday cards on their first birthday. We designed the card ourselves, and it bears the wishes of the Board of Directors. It is far reaching in its effect. For the babies born prior to June we secured the admission cards from the Record Office, and started on June 1st of the previous year. This year our own card system will be complete. We had over 1,600 babies born in the year, so we can count on that number of happy mothers and fathers as likely to support any hospital by-law, for most of them are voters.

Of course this takes a tremendous amount of time, for if there is a telephone in the house of the parents, a call must be put in to ascertain if the baby is still living. At

(Continued on page 24)

How the Publicity Bureau can Keep the Hospital Before the Public Eye

(Continued from page 22)

the same time the name of the baby is secured and the card made even more personal by the addition of the given name. This is done very judiciously in order that no inkling be given that a card is to follow, so that its arrival is a complete surprise. Letters of thanks testify to the value of this plan as a publicity measure.

Early last year we published a pamphlet entitled "Facts You Should Know About the Vancouver General Hospital." This is illustrated with pictures of each department, and contains other useful information besides. It also contains a list of the hospital's aims for the future. In this way the public has been able to gain some idea of our needs, and we hope that any demands for funds will be given generous support because of that.

A most complete history of the hospital since its inception is now being prepared. This will contain many interesting facts hitherto unknown to most citizens. Old-timers are being interviewed and city archives are being searched for old records, so that the history may be as complete and authentic as possible. The history, when published, will contain many illustrations of former buildings and of people who were connected with the institution in its early days.

The nursing staff can also be used along publicity lines. News concerning graduation is of interest. Photographs of prize-winners are eagerly sought by newspapers. Parties being given for the graduation class are the "meat" of the social editors. Activities of the Women's Auxiliary must always be given to the papers the day they occur. I have found that reports of the business meetings at the hospital are always sought by the papers, while the weeklys play up events which happen in the various districts in which events occur. There are many occasions when for some reason papers cannot send their own reporters to Board meetings. In that event the meetings must be reported to them on the nights they occur. News must be given to the newspapers without delay if you are to get the maximum of publicity.

The Publicity Department at the Vancouver General Hospital always keeps in close touch with the General Superintendent. As soon as prominent citizens are admitted to the hospital the Chief is notified "who is within his doors," so that little extra personal services may be given. This again helps to create friendly feeling among those who are in a position to do the hospital a good turn later on.

The radio, another splendid avenue of publicity, is of course available. Although the hospital has not as yet been on the air, it hopes to use this means of publicity as soon as the Radio Fund campaign is inaugurated. During the Radium Week planned, prominent citizens will be asked to co-operate with the hospital in a strenuous drive to secure the necessary funds to purchase radium for the treatment of cancer.

Because of the valuable publicity which Vancouver newspapers give Hospital Day, additional attention was focussed on the hospital by scheduling the graduation exercises of the 1932 class for May 12th. In connection

therewith the papers published several stories, together with the photographs of the prize winners.

Last year the publicity Department took over the publication of the "Nurses' Annual," which had hitherto been a bugbear to the hospital. This was put on a business-like basis, with the result that instead of being a burden it turned out so successfully that a very substantial profit was made. This was added to the Nurses' Benefit Fund.

At Christmas personal letters were sent to all Service Clubs and women's organizations appealing for funds. In this manner many donations were made to the "Christmas Cheer Fund" of the hospital.

I have enumerated our accomplishments to date. We hope to do much more. Providing that a right start is made there is no reason why all other hospitals should not benefit to a great extent by establishing a Publicity Bureau which will devote itself to the fostering of goodwill and the cementing of friendships. There are one or two points which must be borne in mind. In the first place, no complaint, no matter how small it may appear, should be allowed to pass until it has been thoroughly investigated. Why? Because one dissatisfied patient can do more harm in a short time than a publicity department can overcome in a year. It is necessary that every patient leaving the hospital be made feel that he or she has been given the best possible service. Satisfied patients are our best advertisers.

It is also wise to see that the department is staffed by those who have had newspaper experience, because more copy will find its way into the papers if it is written in newspaper language by one who "knows the ropes."

The Economics of Hospital Planning

(Continued from page 10)

Nurses, including dormitory, recreational and teaching—Not less than 4,000 cu ft. for each nurse.

Central kitchen service for a mixed hospital, private, semi-private and ward patients—40,000 cu ft.

Laundry—140 cu. ft. for each bed.

Every hospital architect should be conversant with the equipment for the diagnostic and therapeutic purposes of the physicians, with a view of arranging suitable space for the installation of such equipment. Therefore he must not only familiarize himself with every technical requirement of every branch of the service, but he should acquire so intimate a knowledge of the nature and value of technical procedures that he will be able to apportion space and equipment in the most advantageous way.

It has been conceded that medicine can be practised most effectually in a general hospital which, on the one hand, should not be too small to accommodate the various specialties, but which, on the other, should not be so large as to use up the time and strength of the specialist, either in an unwieldy clinical service or in administrative problems, or to necessitate the awkward physical separation of the clinical departments from each other, thus making intimate co-operation impossible, and indeed making any co-operation whatever workable only through the use of cumbersome administrative machinery.

Quantity Recipe Book of Interest to Dietitians

Hospital dietitians will no doubt find useful a new quantity recipe book for 25-50 servings which has just been published by The Evaporated Milk Association, copies of which may be procured by writing their headquarters at 203 North Wabash Ave., Chicago, Illinois.

In this book are given quantity recipes for delicious soups, salads, salad dressings, cheese, eggs, fish, meats, vegetables, sauces for fish, meat and vegetables, breads, desserts, sauces for desserts, frozen desserts, sauces for ice cream, cake, cookies, cake icings, pies and beverages, all these utilizing evaporated milk.

A valuable table of equivalent weights and measures, marketing suggestions, instructions for souring and whipping evaporated milk, and an index of recipes are extra features of this useful book.

HAMILTON, ONT. — Miss Elizabeth Smellie, chief superintendent of the Victorian Order of Nurses for Canada, who has been invited by the Rockefeller foundation to be their guest on a trip to Europe for the purpose of studying various aspects of maternal welfare, left this city on August 25th for New York to confer with officials of the foundation, and sailed on August 27th.

* * *

SAINT JOHN, N.B.—An important forward step has been taken for the efficiency of the training school of nurses at the General Hospital by the appointment of a full-time instructress, Miss Marion Myers, who reported for duty on Aug. 23. She is a native of Nova Scotia, a graduate of Montreal General Hospital School of Nurses, a post-graduate of McGill University.

* * *

WINNIPEG.—His Excellency, the Earl of Bessborough, formally opened the new wing of the Children's Hospital, the out-patients' department, on August 19th. The money for the building was raised through the work of the four women's hospital guilds, and the labour done under the unemployment relief scheme. Mrs. C. D. Shepherd, president of the board, on His Excellency's right, welcomed the Governor-General.

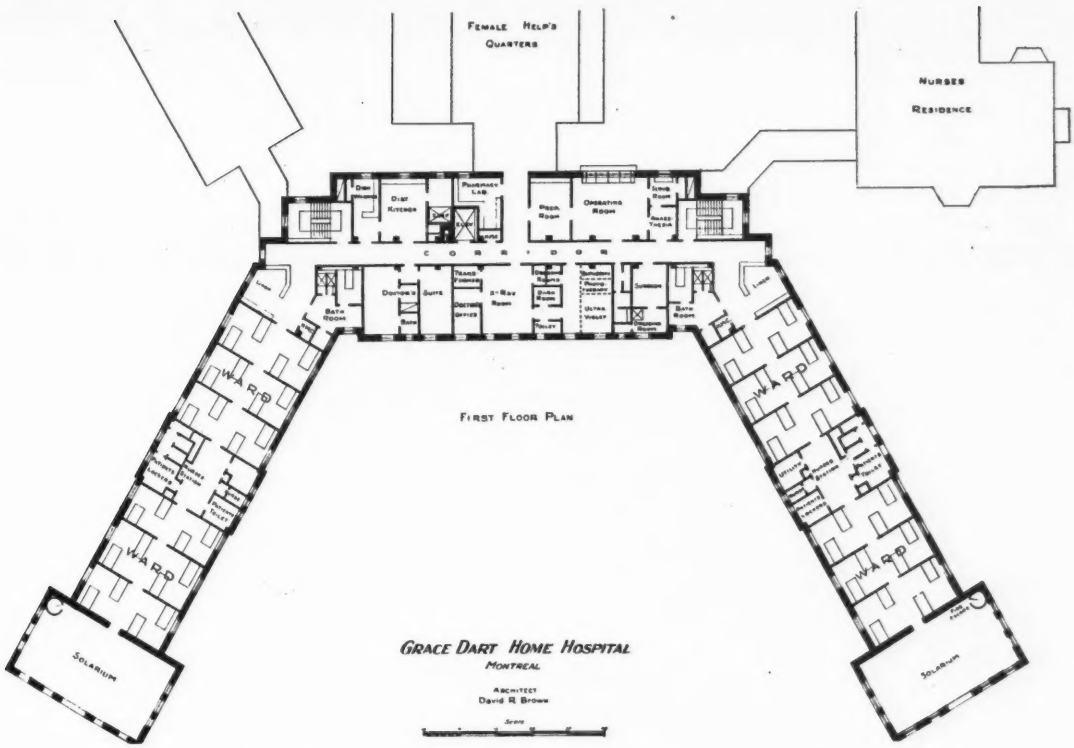
OBITUARY

Dr. Andrew S. Moorhead, F.R.C.S.

TORONTO.—Leading physicians and surgeons, nurses, classmates and scores of friends attended the funeral service at Bloor Street United Church to pay tribute to the memory of Dr. Andrew S. Moorhead, F.R.C.S., outstanding Toronto surgeon, who died on July 31st.

Many of those present were ex-service men who had known Dr. Moorhead overseas, when, as a member of the Canadian and Royal Army Medical Corps, his skill had added to the high record of Canadian surgeons in the Great War. For three years on his return he was chief surgeon of the Pensions Board.

With staff members of Toronto General and Wellesley Hospitals a large body of nurses attended.



Layout of Grace Dart Home Hospital, Montreal, which was formally opened on June 23rd. A feature of this hospital for tuberculosis treatment is the partitioning for every four beds. The wards have cross lighting.

News of Hospitals and Staffs

A Condensed Monthly Summary of Hospital Activities, and Personal News of Hospital Workers

CHARLOTTETOWN, P.E.I.—C. A. Fowler, of Halifax, has been instructed by the Prince Edward Island Government to prepare plans for a new hospital to replace Falconwood Hospital for the Insane, destroyed by fire last winter with a loss of eight lives.

* * *

HAMILTON, ONT.—Rev. Canon Sage of London, Ont., conducted funeral services here on August 15th, for Dr. Walter English, former well-known London doctor and later superintendent of the Ontario Hospital for Criminally Insane in Hamilton, who died two months ago in England. The ashes were interred in Oakland Cemetery at Simcoe. The body had been cremated in England.

Besides members of the family, Dr. McClenahan of the London Ontario Hospital, Dr. Stevenson of the Whitby Ontario Hospital, Dr. J. J. Williams of the Hamilton Ontario Hospital, and Dr. W. C. Herriman of the Toronto Ontario Hospital were among the friends of the deceased present at the funeral.

KITCHENER, ONT.—Sister Helen, who has been appointed superintendent of St. Mary's Hospital by the Mother Superior at Hamilton, as successor to the late Sister M. Bonaventure, has taken up her new duties. The new head of the hospital has had considerable experience in hospital and school work.

* * *

LONDON, ONT.—The City Council on July 18th approved of the by-law to issue $150,000 debentures as their share of the construction of the new civic hospital. The conditions which surround the by-law are rather severe, but it is hoped that the various bodies interested will make every effort to reach an agreement on the methods of building and financing, so that work can proceed.

* * *

MONTREAL.—Most of the new $1,300,000 contagious disease section of the St. Luke Hospital is well advanced, concrete work being completed and stone setting actually under way.

When completed, the new St. Luke Hospital will con-

sist of six storeys, U-shaped, measuring 230 feet by 60 feet. Built of reinforced concrete and brick, artificial stone trim, the building will house 300 beds. A six-storey nurses' residence, boiler house and basement, are being constructed simultaneously at the rear of the main hospital building.

* * *

MONTREAL.—Work on the enlargements and modernization of the existing public ward building of the Hotel Dieu is now proceeding. The intention is to transform the structure into a completely fire-proof, four-storey building which will hold more beds.

The Hotel Dieu is Montreal's oldest hospital, having been founded by Jeanne Mance and Maisonneuve in 1642 when the plans for the city were first laid out. There are 142 nursing sisters in the hospital and some 90 student nurses.

* * *

OTTAWA.—The Hon. Dr. J. M. Robb, Minister of Health for Ontario, opened the new floor of the E. C. Whitney Wing of the Royal Ottawa Sanatorium on July 20th.

* * *

REGINA.—Sister Fennell, former superintendent of St. Paul's Hospital, has been appointed superintendent of St. Peter's Grey Nun Hospital at New Brunswick, New Jersey.

* * *

SAINT JOHN, N.B.—In keeping with the high standard of service prevailing at the General Hospital, a new oxygen tent has been added to their equipment.

* * *

TORONTO.—Dr. Nelson Tait, noted Toronto surgeon, who attended the British Medical Association meeting in London, England, had to undergo a critical operation there on August 14th. He had made arrangements to sail for Canada on the Empress of Britain, but was suddenly taken ill.

His sister, Mrs. Stanley Russell, of Toronto, and his son, remained in London with him, and latest reports are that his condition is satisfactory.

* * *

VANCOUVER.—Dr. George M. Graham, who recently assumed duties as an interne in the General Hospital here, is an honor graduate of University of Toronto and holder of many educational awards.

He received his early education in Ottawa public schools and Ottawa Collegiate Institute. In passing entrance examinations he won the first O. Gara scholarship to be awarded, and on graduating from college he was the recipent of a gold medal for general proficiency and the William Hardie scholarship.

Dr. Graham entered the Biological Medical Science course in the University of Toronto and graduated with first-class honors. During his arts course he won the Sir Daniel Wilson scholarship, and for two successive years the Robert Bruce Bursary.

* * *

CHARLOTTETOWN, P.E.I.—The contract for the construction of the new Prince Edward Island Hospital has been awarded to A. F. Byers & Co., Limited, Montreal, on the basis of a guaranteed maximum price of $204,300, plus a fee of $8,000. The building will be an imposing structure of two storeys and basement.

* * *

HENSALL, ONT.—Huron Springs Sanatorium is the name of a new establishment conducted by Dr. Alex. Moir, about a mile south of this village. Dr. Moir will specialize in radium treatment. Among the many visitors who attended the opening in July was Hon. Dr. John M. Robb, Provincial Minister of Health, who congratulated Dr. Moir upon what he had already accomplished.

* * *

"A hospital is a sanctuary consecrated to the healing of the sick and dedicated to the training of men and women in the art of medicine. Its staff should have a keen sympathy and a genuine love for the work and for the human souls who occupy the sick beds."—*Dr. Abt, Chicago.*

The Cost of Medical Care and Its Implications for Hospital Superintendents

By C. RUFUS OREM, Ph.D.,
Associate for Medical Services, Julius Rosenwald Fund, Chicago.

MEDICAL care is not an ordinary economic commodity. The need for medical care is compulsory; the costs are not predictable either in time or in amount; the buyer is inexpert as a judge of quality; the product is regarded as a social necessity, to be furnished without regard to ability to pay. The need for medical care usually impairs the individual's ability to pay for it, by causing absence from or incapacity for gainful employment. In these respects medical care differs sharply from food, shelter, autos, radios, or entertainment.

C. RUFUS OREM, Ph.D.

A few general facts have been well known with regard to the costs of medical care, for example: that many physicians receive inadequate incomes considering the training and the capital investment in their professional knowledge; that physicians render large amounts of service for which the individual beneficiaries do not pay; that young doctors experience difficulty in establishing a practise; that many hospitals are unable to balance their budgets from patients' fees; that many hospitals are utilized to only partial capacity; that many people need hospital care and do not receive it; that many patients complain of the size of hospital bills; that many nurses have difficulty in earning a reasonable income; that patients often consider special nursing fees too high; that irregular practitioners appear to be thriving in many communities; that large amounts are spent for patent medicines and for drugs for self-medication, most of which are useless, if not actually harmful.

The total annual costs of medical care in the United States at the present time are approximately three and a half billion dollars, or about four per cent. of the estimated national income in normal times. This figure does not appear excessive, in view of the fact that the expenditures for tobacco are a billion and a half dollars, for toilet articles $500,000,000, and for moving pictures a billion and a quarter. Moreover, it is probable that with a better distribution of the burden the American public might carry an even larger load, with resulting benefits of an increased quantity and quality of medical service.

Of the total costs of medical care for the nation approximately 35 per cent. is paid in fees and salaries to physicians and dentists; another 35 per cent. is used to operate and maintain hospitals; approximately 20 per cent. goes for drugs and medicines; about 5 per cent. for the services of non-medical healers; and about 5 per cent. for the combined services for public health work, private duty nursing, and other miscellaneous services.

The average net income of physicians is slightly more than $100 per week or approximately $5,300 per year, according to the estimates of the Committee on the Costs of Medical Care. This average annual income, however, is not realized by all physicians. In 1929 approximately one half of them received $3,800 per year or less. No data are available for 1931 and 1932. Specialists tend to receive higher incomes than general practitioners, and income tends to increase with years of practise. The overhead costs of private practise are between 35 and 40 per cent. of the total cash income received. A physician who receives in cash $7,000 would earn a net income of approximately $5,000 per year. The inescapable conclusion from these facts is that physicians on the average are not receiving unduly high salaries. It would be folly to place the blame for the present dissatisfaction with the costs of medical care upon the large average incomes of medical practitioners. With regard to dentists, the situation is approximately the same, although the average income is somewhat lower. Only about 20 per cent. of the people receive any dental services, although many surveys have indicated that probably as many as 50 per cent. should receive some dental care in the course of a calendar year.

The 7,000 hospitals of the United States, with their 900,000 beds, represent a capital investment of approximately three billion dollars and require annual expenditures of approximately one billion dollars for maintenance and replacement. The capital investment has been furnished by the general public, on a non-profit basis, approximately 90 per cent. having come through voluntary contributions and taxes in about equal proportions. Less than 10 per cent. of the capital investment in the United States has been provided on a business basis, that is, with the expectation of repayment of capital or earnings on the investment. The government units, federal and local, have provided 95 per cent. of the beds for nervous and mental cases, and three fourths of the beds for tuberculosis. Non-government associations dominate the care of acute medical and surgical cases.

Adapted from a speech before the Midwest Hospital Association, St. Louis, Missouri, June 2, 1932.

Hospital endowment has never been an important source of income for the hospitals of the United States. A few of the larger old hospitals in the metropolitan areas control substantial endowment, but for the country as a whole the capital investment in hospital endowment is approximately 400 million dollars. The earnings of this amount, calculated at 5 per cent., would provide approximately eight cents per patient per day toward the operating costs of all hospitals, about two per cent. of the total hospital support of the institutions in the country.

Hospital endowment will probably never be an important factor in the financing of hospital care. The accumulation of endowment capital is a slow process, designed for the future. The need of hospital care is an immediate problem requiring solution in the present. The care of sick patients cannot wait upon the passing of years, and must be financed from day to day through a systematic arrangement by which patients pay for their own medical care or have some one else pay for them.

The annual expenditures for drugs and medicines are approximately $715,000,000. About 20 per cent. of this total amount is definitely prescribed by physicians. Of the remaining 80 per cent., 30 per cent. is for home remedies, and 50 per cent. for secret-formula products for self-medication. There are approximately 150,000 pharmacists in the United States, as many pharmacists as there are physicians. Each pharmacist compounds, on the average, four prescriptions per day, less than 10 per cent. of the number that a pharmacist engaged on a full-time basis could compound in the course of a working day. Pharmacy has become a part-time profession, with the pharmacist spending, roughly, 90 per cent. of his time in the retail business and 10 per cent. at his profession.

The average costs of medical care for the entire country are approximately $25 or $30 per capita, or about $100 per year per family. This average cost does not appear high, considering the expenditures for other items in the course of any given year, and, if it were evenly distributed among all families, or equally distributed among them according to their respective abilities to pay, the economic situation would not be a severe one. But there is a wide disparity between the average and the actual costs of medical care for different families. The costs of medical care in any one year fall very unevenly upon different families in the same income and population group. This was very clearly shown in the Committee's comprehensive nation-wide study of the costs of medical service to 12,000 families. The data were tabulated according to the income of the family and the size of the community in which it is located. Of 2,100 families in cities with from 5,000 to 100,000 population, with annual incomes under $1,200 per year, the average expenditure for medical care was about $80. Approximately 80 per cent. of these families paid less than $60 per year for medical service. At the other end, three per cent. of these low income families were charged $250 or more for their medical service during the year. The 90 per cent. who had charges of less than $60 per year per family paid only 35 per cent. of the total bill for this entire group, whereas the three per cent. with charges of $250 or over per family paid 23 per cent. of the total expenses of this group. Other data from these studies indicate very clearly that for any income group

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and for any size of city approximately 15 per cent. of the population pay approximately 50 per cent. of the costs of medical care.

The individual families, therefore, can derive no particular comfort or assurance from the knowledge that the average cost of medical care is not excessive for families of the average income. If a family should lay aside for medical care four per cent. of its annual income, say $80, it may spend only $8.00 or it may spend $800. The unpredictable nature of sickness renders budgeting for medical care impractical by the individual. A group of people, however, can do what an individual cannot. A group can estimate the total amount of needed medical care and its probable costs during any given period. By a system of group purchase, rather than individual purchase, a number of persons can budget collectively the expenditures for services to individual members requiring medical attention. In addition, such groups may find themselves able to remunerate medical practitioners and institutions more adequately than they do now on the basis of individual payments for medical care. The use of the method of group-purchase is an application of the principle of insurance to the hazard of sickness, which may be faced unexpectedly by any individual. From the point of view of the patient, a system of group-payment *insures medical care* to the beneficiary who requires the services. From the point of view of the doctor or the hospital, a system of group-payment *insures remuneration* for the person or agency who renders the medical service .

Certain definite trends in medical practise have developed with a view either to better co-ordination of specialized personnel and equipment, or to more satisfactory arrangements for the payment of sickness bills. Medical specialists have reduced the overhead costs of their office practise by using common waiting rooms and scientific apparatus and equipment, with each one conducting an independent private practise and maintaining independent financial relationships with patients. Other groups of physicians have formed private group clinics, in which they not only share overhead costs, but also pool their earnings, distributing the net income according to some agreed basis from month to month and from year to year.

In some communities physicians have been relieved from much free service in their private offices by concentrating such service in part-pay clinics, where the physicians are reimbursed a reasonable amount for their time. The patients are charged fees midway between those charged by out-patient departments of hospitals and those current in office practise. Such a plan, of course, is of no value to the indigent patient or one who is unable to pay these fees. It does, however, assist the patient of limited means who is able to pay a limited fee for medical service and who is not logically the recipient of entirely free medical care.

Student health services have been established at many universities, by which students pay a certain amount each term for the costs of their medical care. At the present time most of the leading universities have a more or less fully developed health service, which may cover general

medical care as well as health examinations, and a few have extended the health service to faculty members.

Some hospitals and their medical staffs have developed middle-rate plans for hospital patients, by which the physicians and hospitals co-ordinate their financial arrangements. The physicians agree to render medical services at limited fees to certain patients accepted by the institution. The doctor is placed in full charge of the medical services to the patient, who agrees not to engage expensive hospital accommodations merely to satisfy his vanity, or to employ a private nurse unless recommended by the attending physician. The hospital makes all financial arrangements with the patient and collects the bills. Those hospitals which have experimented with the plan find that the average total costs of a hospitalized illness to patients is reduced, and the actual cash receipts by the doctors is increased.

In the West and Southwestern parts of the United States, groups of employed persons have arranged with groups of physicians to furnish medical services at annual fees payable monthly by each individual eligible for medical care under the agreements. Agreements of this type have been in operation for several years in Dallas, Houston, Fort Worth, Fort Smith, Little Rock, Des Moines, Seattle, Los Angeles, and other cities throughout the various parts of the United States.

These illustrations serve to indicate that at the present time there is a definite trend toward the application of the principle of group practise in the production of medical care and of group purchase in the payment for medical care. What do these trends mean to hospitals and in what way may hospitals themselves profit by the facts revealed? There is both the opportunity and the need for courage and experimentation along two major lines: (1) the reduction of costs, and (2) the increase and stabilization of revenue.

With regard to the reduction of costs, hospital superintendents at the present time are doing everything within their power to reduce total costs of their own institutions. To be sure some economies may be achieved through more careful purchasing or more careful utilization of food and supplies and by a more skillful integration of the purchases made by the various departments in the institution, but the major opportunity for reduced costs in hospital service lies in a fuller utilization of the facilities rather than in reduced salaries or supplies. From the standpoint of the individual hospitals this involves careful planning of the plant and equipment so that the fixed charges and the readiness-to-serve costs can be kept at a minimum. From the standpoint of an entire community, it involves co-operation among hospitals rather than competition.

It is unwise and uneconomical for a community or for a philanthropist to construct a hospital merely to satisfy personal, racial, professional, or religious ambitions. Unless the hospital is actually needed in a community it should not be constructed. Money which has been put into a hospital cannot be recalled for some other public service. Every dollar which goes into unnecessary capital investment makes it more difficult to pay the operating costs of the hospitals which it already has constructed.

From the standpoint of increased and stabilized revenue, hospitals would benefit greatly by application of the insurance principle to the payment of hospital bills. This has been clearly demonstrated by the experiences of two hospitals in Dallas, Texas, which, during the past two years, have put insurance plans into successful operation, covering more than 5,000 beneficiaries for each of the institutions. For a fee of approximately 50 cents per month per person a member is guaranteed 21 days of hospital care during any twelve-months' period and is also given certain reductions on special services of the institution. These benefits do not apply to physicians' fees nor surgeons' fees although there is nothing inherently in the scheme which would rule out the inclusion of these benefits as well. The principle of sickness insurance is a

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reasonable one and is absolutely necessary if people are to budget on a self-respecting and self-supporting basis their costs of medical care, particularly for hospitalized illnesses. Sickness insurance tends to increase the self-respect of the beneficiary and has no tendency to pauperize him. No person is lowered in the economic scale by the improvement of his health. Sickness insurance does not pauperize a person who receives medical care any more than life insurance pauperizes his widow in case he does not.

Sickness insurance is applicable, of course, only to people who collectively pay the costs of their own medical care. What about those who do not, or cannot, pay for their own share of medical care. Governmental hospitals are, of course, serving many free cases at the present time, but non-government hospitals are also expected to care for a number of charity cases. Services to hospital patients cost money. The costs of the care must be paid by some one, by the patient or by the general public.

Hospital superintendents have selected an unfortunate term for describing the difference between patients' fees and operating costs—namely, "deficit." To the business man, this condition implies inefficiency. On the other hand, the difference between operating costs and patients' fees may be regarded merely as a statement of the costs of professional services rendered to the public, a bill which the community should expect to pay promptly and in full by voluntary contributions or by taxes. To the extent that such a bill appears unduly large it should be scrutinized with care. *It is the superintendent's obligation to remove from the community any portion of the economic burden resulting from his own inefficiency, but it is the public's responsibility to remove from the superintendent any portion of the economic burden resulting from the community's demand for hospital care or from an unwise investment by that community in plant and equipment.*

A carefully planned system of accounting and cost analysis would be of immense benefit to a superintendent not only in the control of hospital expenditures, but also in the enlistment of public support. Hospital service is not a homogeneous product. Some departments are self-supporting from patients' fees, some are not. If the total cost of each hospital service were determined separately and correlated with the income from this service such calculations would show clearly the need or opportunity for economy from increased utilization of the hospital's facilities. It would also show clearly which of the various services were not self-supporting from patients' fees. The need for public funds could be traced directly to certain services of the institution. It could in this way be made clear that community support of hospitals is, properly considered, merely the payment of a bill for important public services and not a subsidy for poorly paid hospital administrators.

In summary: The first need in hospital administration at the present time is increased utilization of facilities through the control and co-ordination of capital investment and the realization that a hospital which is built by the public should be administered in such a way as to render the maximum amount of public service. The second need is stabilized revenue. Hospitalized illnesses, because of their irregularity and their relatively high cost, can be budgeted by the individual only through some type of insurance. Just what form this insurance should take is not the immediate problem. But if the patient of moderate means is ever to be self-supporting with regard to hospital care he must be allowed to budget hospital services along with other annual expenditures. For patients who cannot pay the costs of hospital services, either individually or collectively, the community must provide the funds through voluntary contributions or taxation.

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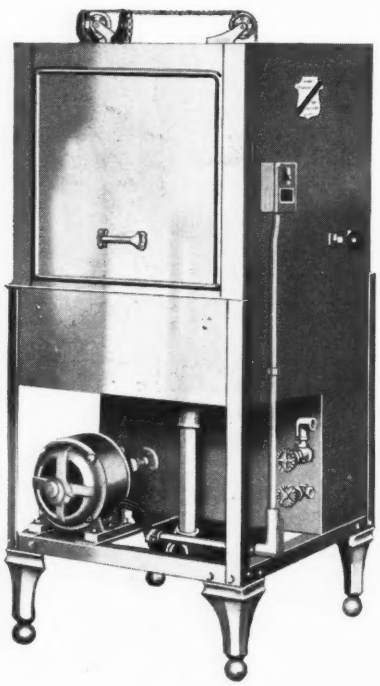

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